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	17E183	A. BUILDING _____ B. WING _____	06/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of the health resurvey and investigations of complaint #56717 in the above named facility.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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This REQUIREMENT is not met as evidenced by:
- Resident # 39's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 5/22/12, indicated the resident had memory problems and severely impaired decision making skills. The MDS indicated the resident was independent with most (ADLs) Activities of Daily Living and received antipsychotic medications in the last 7 days.

The 5/7/12 physician orders, included the following medications:
1) 1/6/12 -Voltaren gel 1% (for pain), 2-4 grams, twice daily to knees.
2) 1/6/12 -Zyrtec (for allergies) 10 milligrams twice daily by mouth.

The 5/23/12 care plan for medication management included side effects for Voltaren gel and Zyrtec.

Review of the April, May and June 2012 (MAR) Medication Administration Record revealed the Voltaren gel 1%, 2-4 grams, to knees twice daily, was not available for the staff to apply to the resident's knees as ordered by the physician, 4/1/12 through 6/5/12. Review of the MARs revealed the physician ordered Zyrtec, was unavailable for the staff to administer to the resident from 5/2/12 through 5/22/12.

On 6/7/12 at 9:20 AM, Nurse C verified the nursing staff failed to notify the physician regarding the unavailable medications. He/She verified the documentation indicated the Voltaren, and Zyrtec were unavailable for a long period.

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(Zyrtec 4/14/12 through 5/22/12) (Voltaren 4/1/12 through 6/6/12)

The facility's Medication Administration Policy, dated 4/24/07, stated medications are to be administered in accordance with written physician orders.

The facility failed to notify Resident #39's physician, in a timely manner, of the medications not being available to administer to the resident as outlined in the physician's order.

The facility had a census of 43 residents. The sample included 11 residents. Based on observation, interview and record review the facility failed to notify the physician a resident's medications were not available to be administered as ordered for 3 of the 11 sampled residents. (#13, #31, #39)

Findings included:

- Resident #13's quarterly (MDS) Minimum Data Set Assessment, dated 5/8/12, indicated the resident scored 13, which indicated intact cognition on the (BIMS) Brief Interview Mental Status. The MDS also revealed the resident was independent with most (ADLS) Activities of Daily Living and required extensive assistance of 1 staff person for bathing.

The current physician's orders dated 5/29/12, instructed the staff to administer the following medications:
1) Lutein, an eye vitamin, 20 mg (milligrams) daily. (initial order date of 4/27/12)

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2) Miralax, a laxative, 17 grams twice a day. (initial order date of 2/5/12)

3) Colace, a stool softener, 100 mg twice a day, (initial order date of 2/3/12)

Review of the April 2012 (MAR) Medication Administration Record revealed the resident did not receive the following medications as ordered:
1) Lutein in the morning on 4/2/12 through 4/6/12.

2) Miralax twice a day on 4/4/12 and 4/5/12.

Review of the June 2012 (MAR) Medication Administration Record revealed the resident did not receive Colace, twice a day, as ordered on 6/2/12 through 6/6/12.

Further review of the resident's chart revealed no documentation in the nurse's notes stating these medications were not available to be administered to the resident or that the staff notified the physician was notified the medications were not available.

On 6/5/12 at 2:25 PM, observation revealed the resident seated at the desk in his/her room with the magnified reader that allowed the resident to read a book.

On 6/6/12 at 4:24 PM, Nurse E verified when a resident's medication is unavailable, the nursing staff should make a note on the back of the resident's MAR and are to notify the physician.

On 6/6/12 at 4:28 PM, Nurse A verified the nurses were to document on the back of the resident's MAR, when a medications not available

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and also notify the physician. Nurse A also verified no documentation in the resident's nurses notes stating the staff notified the physician regarding the resident's medications that were not available to administer.

The 4/24/07 facility policy for Medication Administration stated the resident's medications were to be administered in accordance with written orders from the physician.

The facility failed to notify the physician regarding Resident #13 not receiving the medications Lutein, Miralax and Colace on several occasions..

- Resident #31's quarterly (MDS) Minimum Data Set 3.0 Assessment, dated 5/15/12, revealed the resident scored 8, which indicated a severe cognitive impairment on the (BIMS) Brief Interview of Mental Status. The MDS also indicated the resident required extensive assistance of 1-2 staff person for dressing, grooming and bathing. The MDS also revealed the resident required total assistance with bed mobility, transfers, and propelling in his/her wheelchair, and toileting.

The 6/24/08 physician's order instructed the staff to administer, Synthroid, a thyroid replacement, 0.1 (mg) milligrams daily.

The 6/24/08 physician's order instructed the staff to administer, Prilosec, an anti-ulcer medication, 20 mg daily.

The 11/30/11 physician's order instructed the staff to apply Voltaren Gel 1%, topical

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nonsteroidal anti-inflammatory, in the morning and evening to each knee.

The 5/11/12 physician's order instructed the staff to administer, Xopenex, bronchodilator breathing treatment,1.25 mg, three times a day.

On 6/7/12 review of the resident's (MAR) Medication Administration Record revealed the resident did not receive Voltaren Gel on the following dates:
1). 2/24/12 through 2/29/12
2). 3/1/12 through 3/29/12
3). 4/1/12 through 4/17/12

On 6/7/12 review of the resident's MAR revealed the resident did not receive Xopenex on the following dates:
1). 5/18-5/21/12.

On 6/7/12 review of the resident's MAR revealed the resident did not receive Synthroid and Prilosec on the following date:
1). 4/17/12.

Further review of the resident's chart revealed no documentation in the nurses notes stating these medications were not available to be administered to the resident or that the staff notified the physician the medications were not available.

On 6/6/12 at 1:14 PM, observations revealed the well groomed resident up in wheelchair.

On 6/6/12 at 4:24 PM, Nurse E verified when a medication was unavailable the nursing staff are to make a note on the back of the resident's

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F 157	Continued From page 6 MAR and to notify the physician. On 6/6/12 at 4:28 PM, Nurse A verified the nurses were to document on the back of the resident's MAR, when a medication was not available and also notify the physician. Nurse A also verified no documentation in the resident's nurses notes stating the staff had notified the physician regarding the medication that was not available for administation. Nurse A also verified the pharmacy was unable to obtain the Voltaren Gel as it was not produced for 2 months. The 4/24/07 facility policy for Medication Administration stated the resident's medications were to be administered in accordance with written orders from the physician. The facility failed to notify the physician regarding Resident # 31 not receiving the medications Voltaren Gel, Xopenex, Synthroid or Prilosec on several occasions.	F 157		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	F 280		

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F 280	Continued From page 7 and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility had a census of 43 residents. The sample included 11 residents, 4 of which were reviewed for accidents. Based on observation, record review and interview the facility failed to review and/or revise the plan of care after a fall for 1 of 4 residents.(#38) Findings included: - Resident # 38's annual (MDS) Minimum Data Set 3.0 assessment, dated 2/28/12, indicated the resident had memory problems, severely impaired decision making skills, and required extensive to total 1-2 staff assistance with most (ADLs) Activities of Daily Living. The MDS indicated the resident's balance was unsteady and he/she required human assistance to stabilize. The MDS indicated the resident had 2 non-injury falls and 1 minor injury fall since the prior assessment. The 2/28/12 (CAA) Care Area Assessment summary, indicated the resident required assistance with ADLs and was at risk for falls. The summary indicated the resident no longer ambulated, had a history of falls and had 3 falls since the last MDS.	F 280		

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The 3/7/12 Care Plan indicated a fall risk score of 14, which indicated a high risk for falls. The care plan directed the staff to provide 1-2 staff assistance with ADLs, use 2 person pivot transfer with a gait belt and a wheelchair for mobility. The care plan indicated the resident had the potential for falls due to a history of falls. The care plan directed the staff to place a pressure alarm pad on the resident's bed, chair and a pressure alarm pad on the floor by the bed, and ensure the devices are turned on. The care plan directed the staff to assess for the cause of falls and complete a post fall monitoring per protocol.

Review of the resident's medical record revealed he/she had a fall on 4/8/12, 5/17/12 and on 5/29/12.

Review of the care plan revealed no revision/review after the 5/17/12 fall. Further review of the medical record revealed the resident fell again on 5/29/12, before the staff had reviewed the care plan.

On 6/5/12 at 10:37 AM, observation revealed the resident in bed and the bed in low position, a mat on floor by the bed and the call light within reach. Further observation revealed a winged mattress on the bed, the door open, floor mat alarm and bed alarm on.

On 6/7/12 at 9:50 AM, Nurse A stated staff are to review or update the care plan after each fall and he/she verified the care plan lacked any review or update regarding the resident's fall on 5/17/12.

The facility failed to review and/or revise Resident

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F 280	Continued From page 9 #38's plan of care after the fall on 5/17/12 and the resident experienced another fall on 5/29/12.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: - On 6/4/12 at 10:20 AM, observation in the dining room revealed an unmarked quart size spray bottle of pink liquid under the sink. Dietary Staff B stated the staff should have placed a label on the bottle and stated the spray bottle contained sanitizer and should be placed in a locked cabinet. The facility failed to ensure potentially hazardous chemicals were not accessible to the 8 cognitively impaired, independently mobile residents of the facility. The facility had a census of 43 residents.The sample included 11 residents. Based on observation, interview and record review, the facility failed to provide an environment that is free from accident hazards for 8 cognitively impaired independently mobile residents. Findings included:	F 323		

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F 323	Continued From page 10 - On 6/4/12 at 10:20 AM, during initial tour of the facility, observation of the north hall whirlpool room revealed a gallon jug of whirlpool disinfectant sitting on the floor by the whirlpool. The bottle stated "Danger,keep out of reach of children, corrosive, causes irreversible eye damage and skin burns, do not get in eyes,on skin, or on clothing.Harmful if swallowed." On 6/4/12 at 10:25 AM, observation of the west whirlpool room revealed an unlocked cabinet with a 16 ounce spray bottle of Re-Juv-nal disinfectant.The label stated "Keep out of reach of children." On 6/4/12 at 10:27AM, Nurse D verified the chemicals in the north and west whirlpool rooms and also verified the chemicals were to be locked up. On 6/7/12 at 9:30 AM, Nurse A revealed the facility had 8 cognitively impaired, independently mobile residents. Nurse A verified chemicals should not be accessible to residents. On 6/7/12 at 2:00 PM, Nurse A revealed the facility did not have a policy for the storage of chemicals. The facility failed to provide an environment free of chemical accident hazards for 8 cognitively impaired residents.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	F 329		

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F 329	Continued From page 11 duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: The facility had a census of 43 residents. The sample included 11 residents, of which 10 were reviewed for unnecessary drugs. Based on observation, record review and interview the facility failed to ensure potential side effects, such as constipation, were monitored for 1 of 10 sampled residents. (#26) Findings included: - Resident # 26's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 3/27/12, indicated the resident had memory problems with severely	F 329		

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impaired decision making skills. The MDS indicated the resident required extensive to total 1-2 staff assistance for (ADLs) Activities of Daily Living.

The 1/24/12 Physician's Standing Orders directed the staff to provide the following bowel program:
Day #1) offer 120 (cc) cubic centimeters, prune or grape juice,
Day #2) give 30 cc (MOM) Milk of Magnesia, in the morning if no (Bowel Movement) BM the day before, administer a dulcolax suppository in the evening if still no BM.
Day #3) fleets enema in the morning if bowels have not moved the day before, repeat program every 3rd day.

The 3/21/11 Physician's order directed the nursing staff to review the resident's bowel movement record and, if applicable, implement the bowel regime after day 3.

The resident's bowel record indicated no BM 4/8/12 through 4/13 (6 days), 4/28 through 5/5 (8 days), 5/8 through 5/13 (6 days), 5/20 through 5/24 (4 days) .

Review of the April and May 2012 (MAR) Medication Administration Record indicated staff gave the resident prune juice on 5/5 (after 8 days without a documented bowel movement). The MAR indicated MOM was given 5/5 (after 8 days without a BM) and on 5/18, 5/19, and 5/24 (after 4 days without a BM). Further review of the MAR revealed no other interventions for the lack of bowel movements. Review of the medical record revealed no assessments of bowel sounds and no other documentation regarding the lack of

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F 329	Continued From page 13 bowel movements. On 6/6/12 at 7:25 AM, observation revealed the resident in bed with his/her eyes closed. On 6/6/12 at 2:55 PM, Nurse C stated the night shift nurse notifies the day shift nurse if a resident is in need of bowel intervention. He/She verified the lack of documentation of bowel assessment or interventions for the resident's lack of bowel elimination, as directed by the Physician's Standing Orders. The facility failed to monitor, assess and provide interventions for Resident #26 who experienced constipation.	F 329		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425		

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This REQUIREMENT is not met as evidenced by:
- Resident # 39's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 5/22/12, indicated the resident had memory problems and severely impaired decision making skills. The MDS indicated the resident was independent with most (ADLs) Activities of Daily Living and received antipsychotic medications in the last 7 days.

The 5/7/12 physician orders included the following medications:
1) Voltaren gel 1% (for pain), 2-4 grams, twice daily to knees, originally ordered 1/6/12.
2) Zyrtec (for allergies) 10 milligrams twice daily by mouth, originally ordered 1/6/12.

The 5/23/12 care plan for medication management included side effects for Voltaren gel and Zyrtec.

Review of the April, May and June 2012 (MAR) Medication Administration Record revealed the Voltaren gel 1%, 2-4 grams, to knees twice daily, was not available for the staff to apply to the resident's knees as ordered by the physician, 4/1/12 through 6/5/12. Review of the MARs revealed the physician ordered Zyrtec, was unavailable for the staff to administer to the resident from 5/2/12 through 5/22/12.

Review of the facility's Pharmacist Consultant Reviews revealed no documentation or recommendations regarding the unavailable

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F 425	Continued From page 15 medications, Voltaren and Zyrtec. On 6/7/12 at 9:20 AM, Nurse C verified the documentation indicated the Voltaren, and Zyrtec were unavailable for a long period. (Zyrtec 4/14/12 through 5/22/12) (Voltaren 4/1/12 through 6/6/12) On 6/7/12 at 10:00 AM, Nurse A stated the pharmacist Consultant did not address the issue of the unavailable medications (Voltaren gel and Zyrtec). The facility's Medication Administration Policy, dated 4/24/07, stated medications are to be administered in accordance with written physician orders. The facility failed to acquire, receive, dispense and administer all of the prescrbed medications for 3 of the 11 sampled residents. The facility had a census of 43 residents. The sample included 11 residents. Based on interview, record review and observation the facility failed to provide pharmaceutical services that assure the accurate acquiring, receiving, dispensing and administering of all drugs to meet the needs of 3 of the 11 sampled residents (#13, #31 and #39). Findings included: - Resident #13's quarterly (MDS) Minimum Data Set Assessment, dated 5/8/12, indicated the resident scored 13, which indicated cognition intact on the (BIMS) Brief Interview Mental Status.	F 425		

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The MDS also revealed the resident was independent with most (ADLS) Activities of Daily Living and required extensive assist of 1 staff person for bathing.

The current physician's orders dated 5/29/12, instructed the staff to administer the following medications:
1) Lutein, an eye vitamin, 20 mg (milligrams) daily. (initial order date of 4/27/12)

2) Miralax, a laxative, 17 grams twice a day. (initial order date of 2/5/12)

3) Colace, a stool softener, 100 mg , twice a day, (initial order date of 2/3/12)

Review of the April 2012 (MAR) Medication Administration Record revealed the resident did not receive the following medications as ordered:
1) Lutein in the morning on 4/2/12 through 4/6/12.

2) Miralax, twice a day, on 4/4/12 and 4/5/12.

Review of the June 2012 (MAR) Medication Administration Record revealed the resident did not receive Colace, twice a day, as ordered on 6/2/12 through 6/6/12.

Further review of the resident's chart revealed no documentation in the nurse's notes stating these medications were not available to be administered to the resident or that the staff notified the physician the medications were not available.

On 6/5/12 at 2:25 PM, observation revealed the resident seated at the desk in his/her room with

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the magnified reader that allowed the resident to read a book.

On 6/6/12 at 4:24 PM, Nurse E verified when a resident's medication was unavailable, the nursing staff should make a note on the back of the resident's MAR and notify the physician.

On 6/6/12 at 4:28 PM, Nurse A verified the nurses were to document on the back of the resident's MAR, when a medication's not available and also notify the physician. Nurse A also verified no documentation in the resident's nurses notes stating the staff notified the physician regarding the resident's medications that were not available to administer.

The 4/24/07 facility policy for Medication Administration stated the resident's medications were to be administered in accordance with written orders from the physician.

The facility failed to acquire, receive, dispense and administer all of the prescrbed medications for 3 of the 11 sampled residents.

- Resident #31's quarterly (MDS) Minimum Data Set 3.0 Assessment, dated 5/15/12, revealed the resident scored 8, which indicated a severe cognitive impairment on the (BIMS) Brief Interview of Mental Status. The MDS also indicated the resident required extensive assistance of 1-2 staff person for dressing, grooming and bathing. The MDS also revealed the resident required total assistance with bed mobility, transfers, and propelling in his/her wheelchair, and toileting.

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The 6/24/08 physician's order instructed the staff to administer, Synthroid, a thyroid replacement, 0.1 (mg) milligrams daily.

The 6/24/08 physician's order instructed the staff to administer, Prilosec, an anti-ulcer medication, 20 mg daily.

The 11/30/11 physician's order instructed the staff to apply Voltaren Gel 1%, topical nonsteroidal anti-inflammatory, in the morning and evening to each knee.

The 5/11/12 physician's order instructed the staff to administer, Xopenex, bronchodilator breathing treatment,1.25 mg three times a day.

On 6/7/12 review of the resident's (MAR) Medication Administration Record revealed the resident did not receive Voltaren Gel on the following dates:
1). 2/24/12 through 2/29/12
2). 3/1/12 through 3/29/12
3). 4/1/12 through 4/17/12

On 6/7/12 review of the resident's MAR revealed the resident did not receive Xopenex on the following dates:
1). 5/18-5/21/12.

On 6/7/12 review of the resident's MAR revealed the resident did not receive Synthroid and Prilosec on the following date:
1). 4/17/12.

Further review of the resident's chart revealed no documentation in the nurses notes stating these medications were not available to be

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F 425	Continued From page 19 administered to the resident or that the staff notified the physician the medications were not available. On 6/6/12 at 1:14 PM, observation revealed the well groomed resident up in wheelchair. On 6/6/12 at 4:24 PM, Nurse E verified when a medication is unavailable the nursing staff are to make a note on the back of the resident's MAR and to notify the physician. On 6/6/12 at 4:28 PM, Nurse A verified the nurses were to document on the back of the resident's MAR, when a medication is not available and also notify the physician. Nurse A also verified no documentation in the resident's nurses notes stating the staff had notified the physician regarding the medication that was not available for administation. Nurse A also verified the pharmacy was unable to obtain the Voltaren Gel as it was not produced for 2 months. The 4/24/07 facility policy for Medication Administration stated the resident's medications were to be administered in accordance with written orders from the physician. The facility failed to acquire, receive, dispense and administer all of the prescrbed medications for 3 of the 11 sampled residents.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		

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F 428	Continued From page 20 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: The facility had a census of 43 residents. The sample included 15 residents. Based on observation, record review and interview, the facility's pharmacist consultant failed to report irregularities to the resident's physician and the facility's director of nursing. - Resident # 39's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 5/22/12, indicated the resident had memory problems and severely impaired decision making skills. The MDS indicated the resident independent with most (ADLs) Activities of Daily Living and received antipsychotic medications in the last 7 days. The 5/7/12 physician orders included the following medications: 1) Voltaren gel 1%, 2-4 grams, twice daily to knees, originally ordered 1/6/12. 2) Zyrtec 10 milligrams twice daily by mouth, originally ordered 1/6/12. The 5/23/12 care plan for medication management included side effects for Voltaren gel and Zyrtec. Review of the April, May and June (MAR) Medication Administration Record revealed the	F 428		

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F 428	Continued From page 21 Voltaren gel 1%, 2-4 grams, to knees twice daily, was not available 4/1/12 through 6/5/12. Review of the MARs revealed the physician ordered Zyrtec was unavailable 5/2/12 through 5/22/12. On 6/7/12 at 9:20 AM, Nurse C stated the nursing staff should have notified the physician regarding the unavailable medications. He/She verified the documentation indicated the Voltaren gel, and Zyrtec were unavailable for a long period. (Zyrtec 4/14/12 through 5/22/12) (Voltaren 4/1/12 through 6/6/12) On 6/7/12 at 10:00 AM, Nurse A stated the facility's Pharmacist Consultant did not address the issue of the unavailable medications (Voltaren gel and Zyrtec) for Resident #39. The facility's Pharmacist Consultant Agreement, dated 10/27/99, stated the consultant pharmacist shall be responsible for a monthly review of the drug regimen of each resident with reports of any irregularities to the nurse in charge and or the attending physician. The facility's Pharmacist Consultant failed to report to the Director of Nursing or the resident's physician that Resident #39 did not receive 2 medications, that were physician ordered, due to the unavailability for several weeks.	F 428		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		

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F 441	Continued From page 22 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: - On 6/4/12 at 11:25 AM, observation revealed 4 oxygen concentrators in the dining room with tubing and the nasal cannula on top without a cover on the nasal cannula.	F 441		

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F 441	Continued From page 23 On 6/5/12 at 8:42 AM, observation revealed a resident self propelled his/her wheelchair away from the dining table and took off his/her oxygen tubing. The nasal cannula landed on the floor and drug behind the wheelchair for a few feet before an aide stopped him/her and placed the nasal cannula back into the resident's nose. Aide F verified the oxygen tubing and cannula was drug on the floor behind the wheelchair. Aide F also stated the resident frequently took off his/her oxygen tubing when moving from the dining room to his/her room and the tubing frequently fell to the floor. On 6/5/12 at 8:55 AM, Nurse C stated the staff should not have placed the soiled cannula back into the resident's nose. Nurse C stated the staff should dispose of the nasal cannula. Nurse C stated the staff used to place the nasal cannulas in a bag on the concentrator, but have not done that for a while. On 6/6/12 at 1:45 PM, observation revealed 5 of 5 oxygen concentrators with nasal cannulas coiled on top of the concentrators with no covering to prevent contamination. On 6/7/12 at 9:50 AM, Nurse A stated the residents' nasal cannulas should be covered to protect them from contamination when not observed by the staff. The facility failed to provide infection control measures to ensure the residents' nasal cannulas remained free of contamination and failed to replace the contaminated nasal cannula for the unsampled resident.	F 441		

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The facility had a census of 43 residents. The sample included 11 residents . Based on observation, interview and record review the facility failed to provide a safe, sanitary environment to prevent the development and transmission of infection.

Findings included:

- On 6/4/12 at 11:40 AM, observation of the dining room revealed 8 oxygen concentrators placed at different areas throughout the dining room area. Three of the 8 oxygen concentrators had the nasal cannulas (part of the oxygen tubing that is inserted into the nose) laying on the dining room floor. Further observaton revealed an unsampled resident wheeled him/herself into the dining room and picked up one of the nasal cannula's off the floor and placed it in his/her nose and then turned the oxygen concentrator on.

On 6/5/12 at 7:50 AM, observation revealed an unsampled resident in the dining room seated in his/her wheelchair. The resident wheeled his/her wheelchair over to an oxygen concentrator and picked up the nasal cannula off the floor and placed it in his/her nose.

On 6/5/12 at 8:30 AM, Nurse D verified the oxygen tubing had been laying on the floor in the dining room.

On 6/7/12 at 2:00 PM, Nurse A indicated the facility did not have a policy for care of oyxgen

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F 441	Continued From page 25 tubing. The facility failed to provide care for oxygen tubing to maintain a safe sanitary environment for the prevention of the spread of infection for residents who receive oxygen.	F 441		